

# FSA

## ENROLLMENT BOOKLET

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# It's Time to Enroll in Flex Benefits

**Flexible Spending Accounts (FSAs) are a great way to save taxes on money you spend for medical and dependent care expenses.**

That's because you do not pay income tax or Social Security tax on your election amount (the money you set aside). A Health FSA account is used for medical expenses, and a Dependent Care FSA (also known as a Dependent Care Assistance Plan) is used for child care expenses.

## Health FSA

In a Health FSA account, you can put aside funds (up to the max per year, depending on your plan) to pay for unreimbursed medical, dental and vision expenses (that is, bills that are not paid by any insurance). This money is deducted from your pay before Federal and State withholding and FICA taxes are calculated. To access your FSA funds to pay medical expenses, just use your Mastercard® debit card to pay the bill (avoiding out-of-pocket cost), or file a manual claim for reimbursement by fax, email, postal mail, online, or via mobile app. Reimbursements can be deposited directly into your bank account.

*To see a list of qualified medical expenses, see page 5.*

## Dependent Care Assistance Plan

With a Dependent Care FSA, you can set aside up to \$7,500 through your employer's cafeteria plan to cover care expenses for dependents while you're at work. DCAP applies to children from birth until their 13th birthday and can reimburse for daycare, preschool and pre-kindergarten, before- and after-school care, and summer camp (day camp only). You can also use a Dependent Care FSA to cover care costs for adult dependents who cannot take care of themselves while you're working.

### Flexible Spending Account (FSA) Contribution Limits:

Health FSA: \$3,300  
Dependent Care FSA: \$7,500

## FSA Debit Card

Your employer is offering an FSA debit card to allow you to pay for eligible expenses without being out-of-pocket and waiting for reimbursement. The debit card is a payment facilitator that can be used at healthcare facilities, doctors, dentists and orthodontists, vision care providers, drug stores, and selected retailers.



*You will receive a blue Summit benefits debit card.*

Your debit card will be automatically approved when used for FSA-eligible items at any approved IIAS Qualified Merchant. When using your debit card, be sure to keep all receipts. Your benefits administrator may request them at any time to verify your purchase.

# FSAs & Debit Card FAQs

**Q: What if I am not covered or I do not have my dependents covered under my company's health insurance plan?**

**A:** You and your family can still participate in the Health FSA or Dependent Care reimbursement account.

**Q: Why should I participate in the Health FSA when I already have health insurance?**

**A:** The Health FSA is used to pay for expenses that are not covered by most health insurance policies, such as co-payments, co-insurance, prescription drugs, glasses and contacts, orthodontics, dental care, and certain over-the-counter items, to name a few.

**Q: Do I need to have a lot of expenses?**

**A:** No. You should put aside only enough funds to cover what you expect to spend during the plan year. If you do not use the money, the IRS mandates that you lose it, unless your plan allows unspent Health FSA monies (up to a maximum of \$660) to be carried over to the next plan year. Review your Summary Plan Description (SPD) to see if your plan includes Carryover.

**Q: How do I figure how much to set aside?**

**A:** Review receipts and check registers to see what you typically spend out-of-pocket on medical expenses for yourself and qualified family members. Then think about what might be different this year that would cause an increase or decrease. *Use the FSA worksheet provided.*

**Q: What is the minimum/maximum amount that I can put into my account?**

**A:** These amounts are determined by your employer and specified in your SPD. The maximum cannot exceed the IRS-mandated maximums. See the top of page 2.

**Q: When must expenses be incurred in order to receive reimbursement under the Health FSA?**

**A:** Eligible medical expenses must be incurred during the plan year and while you are a Plan participant. "Incurred" means that the service or treatment has been provided. If you pay for an eligible expense in advance, you cannot be reimbursed until the service or treatment has actually been received. You also cannot be reimbursed with current plan year funds for expenses incurred:

- Before the plan year began;
- Before your election form became effective;
- After the close of the plan year; or,
- After a job separation or loss of eligibility (unless incurred during an applicable COBRA continuation period).

## FSA Worksheet

Use this to estimate the amount you want to set aside in your flexible spending accounts

Insurance Deductibles .....	\$ _____
Insurance Co-Pays.....	\$ _____
Dental Deductibles.....	\$ _____
Dental Expenses .....	\$ _____
Vision Deductibles.....	\$ _____
Vision Expenses .....	\$ _____
Hearing Expenses.....	\$ _____
Prescriptions.....	\$ _____
Medical Equipment .....	\$ _____
Chiropractor.....	\$ _____
Other Medical Expenses.....	\$ _____
Total Out-of-Pocket Medical Expenses.....	\$ _____
Divide by No. of Pay Periods Per Year .....	÷ _____
= Per-Payroll Deduction For Health FSA.....	\$ _____

## Dependent Care for Children under 13 years of age

Cost Per Week .....	\$ _____
Multiply by 52 weeks .....	X _____
Total Annual Cost.....	\$ _____
(Maximum \$7,500)	
Divide by No. of Pay Periods Per Year.....	÷ _____
= Per-Payroll Deduction For DCAP .....	\$ _____



# FSA's & Debit Card FAQs

**Q: How do I access my FSA funds? What is the Summit debit card?**

**A:** You will receive a benefits debit card that is linked to your FSA account. This is a limited-purpose Mastercard® that is coded for medical providers only. Having the Summit debit card lets you cover qualified expenses without first having to pay out-of-pocket and then wait for reimbursement. Although you have the option of setting a PIN for your card, a PIN is not necessary; to pay an expense, just swipe the Summit debit card as you would a regular credit card. If for any reason you did not use your card to pay an eligible expense, you can submit a claim for reimbursement (also known as a “request for distribution”).

**Q: Do I have to keep up with receipts?**

**A:** You should always keep your receipts, even when you use your FSA debit card. With an FSA card, your transactions should automatically be approved, however, your administrator may ask for the receipt at any time in order to verify a transaction. Without an FSA card, you will have to send in a signed claims form with valid claims documentation.

**Q: What is required as claims documentation?**

**A:** You must submit a copy of your statement, invoice, visit record, explanation of benefits (EOB), or other document that shows the date and type of service, amount charged, and provider. Canceled checks and credit card slips are not qualified receipts.

**Q: What if I have a claim early in the plan year and do not have enough money in my account?**

**A:** You are eligible for 100% of your Health FSA election at the start of the plan year, due to the “Uniform Coverage Rule.” Your payroll deductions will continue throughout the plan year to catch up on any expenses you have been advanced. For the Dependent Care FSA, you will be reimbursed as your deductions are deposited with your employer.

**Q: If I put my own pre-tax money in a spending account, why would I lose it if I don't spend it?**

**A:** This is an IRS requirement. If your plan does not include Carryover, you may have a grace period of up to 2.5 months from the end of the plan year to use any leftover funds. You may also have a run-out period from the end of the plan year to submit eligible claims. Refer to your SPD.

**Q: Can I change my contributions during the year?**

**A:** Only if you experience a qualified change of status, such as marriage, divorce, birth, adoption, or a change in your or your spouse's employment status.

**Q: Can Dependent Care expenses be reimbursed at the beginning of the month for care that will be provided later in that month?**

**A:** No, regulations require that Dependent Care claims can only be reimbursed when a service has actually been received. If you pay in advance for a certain period of time, you cannot be reimbursed until the period has ended (i.e., until the care has been received).

**Q: Can an employee who participates in Dependent Care FSA also claim the Dependent Care Tax Credit?**

**A:** No. There is no ‘double-dipping.’ If you are using a DCAP you may not also elect the tax credit on the same money. Please consult with a tax preparer for more information.

**Q: Does the provider have to do anything different to take the FSA debit card?**

**A:** No. The card is compatible with standard Mastercard processing systems. The only requirement is that the provider's credit card Merchant Category Code matches one of those assigned to qualified goods and services (i.e., the card will not work at a gas station, pet store, hair salon, etc.)

**Q: What if there is not enough money in my FSA when I swipe the card to pay an expense?**

**A:** If the transaction exceeds your available balance (purse value), usually it will be declined. Some merchants can accept “split tender,” which means their system is able to charge your card only for the portion that equals your available balance and then ask for a different form of payment to cover the remainder.

**Q: Are there any transaction limits on my FSA debit card?**

**A:** Both the per-transaction limit and the maximum combined daily transaction limit for the Summit debit card is \$5,000.

**Q: How can I check my account balance, card transactions, status of reimbursement claims, and so on?**

**A:** You have account access 24 hours a day through your Summit online employee portal and through the Summit mobile app. To register and log in for the first time, refer to the welcome email that your benefits administrator will send after enrollment.

**Q: What if I still need help after looking at my account?**

**A:** Contact Beneliance, whose information can be found on the back cover of this enrollment booklet.

# Eligible/Non-Eligible Expenses

## FSA/HSA Eligible Health Care Expenses

Please note that we do not intend this list to be comprehensive tax advice. For more detailed information, please consult IRS Publication 502 or see your tax advisor. **\*If prescribed for a particular ailment or medical condition; provider letter required.**

Acupuncture	Eye examinations and eyeglasses	Physical exams
Alcoholism treatment	Home health and/or hospice care	Physical therapy
Allergy shots and testing	Hospital services	Psychiatric care ( <i>psychologists, psychotherapists</i> )
Ambulance ( <i>ground or air</i> )	Insulin	Radial keratotomy
Artificial limbs	Laboratory fees	Schools ( <i>special, relief, or handicapped</i> )
Blind services and equipment	LASIK eye surgery	Sexual dysfunction treatment
Car controls for handicapped*	Medical alert ( <i>bracelet, necklace</i> )	Smoking cessation programs
Chiropractor services	Medical monitoring and testing devices*	Surgical fees
Coinurance and deductibles	Nursing services	Television or telephone for the hearing impaired
Contact lenses	Obstetrical expenses	Therapy treatments*
Crutches, wheelchairs, walkers	Occlusal guards	Transportation ( <i>essentially and primarily for medical care; limits apply</i> )
Dental treatment	Operations and surgeries ( <i>legal</i> )	Vaccinations
Dentures	Optometrists	Vitamins*
Diagnostic tests	Orthodontia	Weight loss programs*
Doctor's fees	Orthopedic services	X-rays
Drug addiction treatment & facilities	Osteopaths	
Drugs ( <i>prescription</i> )	Oxygen/oxygen equipment	

## FSA/HSA Eligible OTC Medications and Products

Acne medications & treatments	Braces & supports	Laxatives
Allergy & sinus, cold, flu & cough remedies	Contact lens solution	Medicated bandaids & dressings
Antacids & acid controllers	Contraceptives ( <i>condoms, gels, foams, suppositories, etc.</i> )	Menstrual care products
Antibiotic & antiseptic sprays, creams & ointments	CPAP equipment & supplies	Motion sickness remedies
Anti-diarrheals	Diabetic testing supplies/equipment	Nicotine patches and other smoking cessation aids
Anti-fungals	Durable medical equipment ( <i>power chairs, walkers, wheelchairs, etc.</i> )	OTC varieties of Insulin
Anti-gas & stomach remedies	Eczema & psoriasis remedies	Pain relievers ( <i>aspirin, ibuprofen, acetaminophen, naproxen, etc.</i> )
Anti-itch & insect bite remedies	Eye drops, ear drops, nasal sprays	Personal protection equipment (PPE) for COVID-19
Anti-parasitics	First aid kits	Reading glasses
Digestive aids	Hemorrhoidal preparations	Sleep aids & sedatives
Baby care ( <i>diaper rash ointments, teething gel, rehydration fluids, etc.</i> )	Home diagnostics (pregnancy tests, ovulation kits, thermometers, blood pressure monitors, etc.)	Wart removal remedies, corn patches
Bandages and bandaids	Hydrogen peroxide, rubbing alcohol	
Breast pumps for nursing mothers		<b>All OTC items listed are examples.</b>

**These items are commonly mistaken as eligible but do not meet the requirements:**

Cosmetic surgery and procedures	Health programs, health clubs and gyms	Teeth whitening
Cosmetic dental procedures (incl. teeth whitening, vitamins and supplements)	Insurance premiums (not reimbursable under FSA)	Vitamins & supplements without prescription

# Welcome to Mobile Summit

## Benefits at Your Fingertips

Access your employee benefits account information on your mobile device with the Mobile Summit app for Apple and Android.

## What You Can Do with Mobile Summit

- ✓ **View Accounts** – Access detailed balance and account information, including alerts.
- ✓ **Card Activity** – Review transaction information, including whether receipts are needed.
- ✓ **Enter a Claim** – Easily file a claim using your smartphone or mobile device. Just open a claim using the app, fill in some details onscreen, take a photo of the receipt with your smartphone camera, and upload. Claims filing couldn't be easier!



## Locating and Loading the Mobile Summit App



Search for "Mobile Summit" on the App Store for Apple products or in the Google Play Store for Android products, and load as you would any other app.

## Logging in

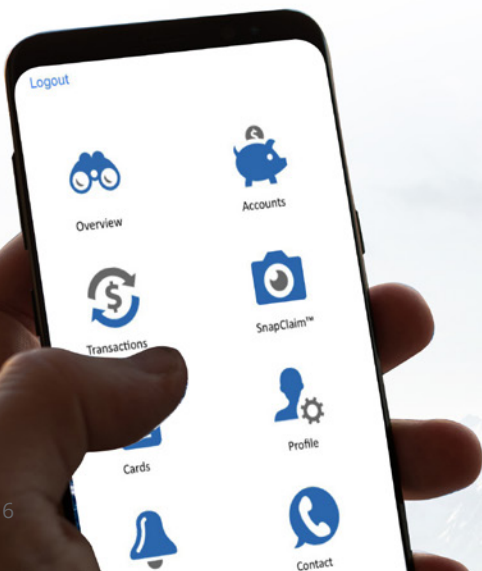
Mobile Summit uses the same login credentials as the online participant portal. Once you have registered online, log in to Mobile Summit using the same username, password, and TPA code.\* After logging in to the app, you will be on the home page which lists your navigation options.

*\*Our TPA code is 159. If you do not remember that code, you can enter our web address for the Summit participant portal: <https://benefits.summitfor.me>*



## Getting Help

Click the Contact icon located in the 3 line menu at the top of the page to access contact information for your administrator, who will be able to provide assistance.



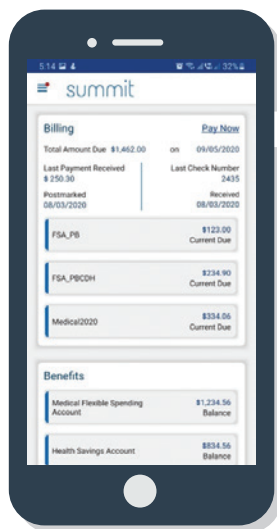
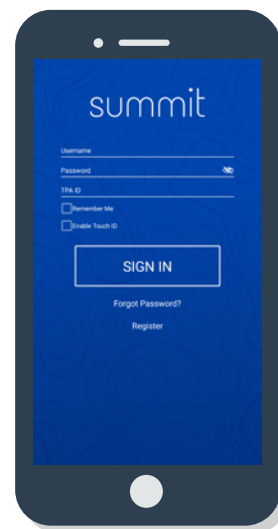
# summit Mobile Quick Start Guide

## Logging In

Open the Mobile Summit app. Use the same username and password to log in that you use to log in to the full Summit portal online.

## What You Can Do with Mobile Summit

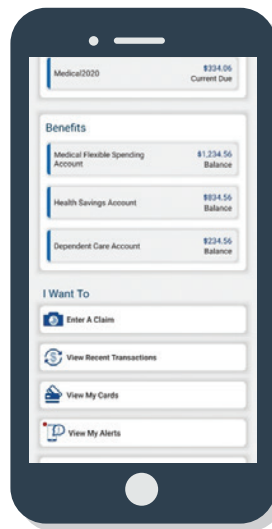
Once you log in, the Home page displays on the screen. Tap the icons to access the available features:



## Homepage –

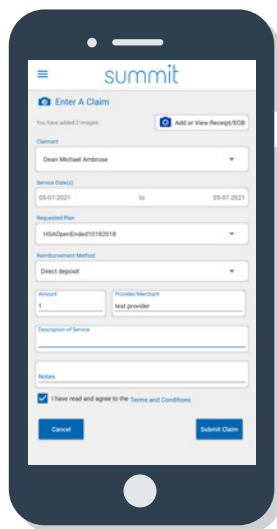
**The Billing section** will display for participants who have at least one Premium Billing coverage (COBRA, direct or retiree billing). View details about your account or click Pay Now to pay a premium that is due.

**The Benefits section** displays all active and prior year benefits and their balance for participants with CDH benefits (FSA, DCAP, HRA, HSA, Transit). Navigate to the Account Detail page by clicking on a particular benefit.



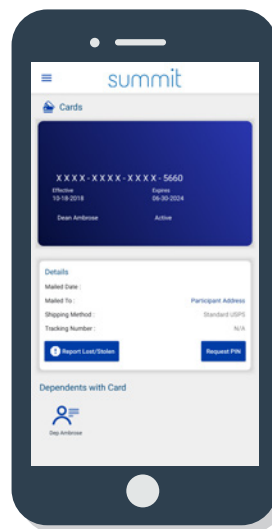
## I Want to –

**The I Want To** section at the bottom of the homepage allows you to quickly access available features of the app. You can easily navigate to enter a claim, request a withdrawal or reimbursement, view recent transactions, view alerts, and update your profile. Premium Billing only participants will see the menu items that pertain to billing activities.



## Enter a Claim –

**Mobile Summit** provides a quick, convenient, and secure way to file claims using your smartphone's camera. Enter claim information including Claimant, Service Dates, Amount, Provider/Merchant, and Reimbursement Method, then upload a photo of the receipt or EOB, and submit for processing.



## Cards –

**View card details** shows the name on the card issued to you, the card number, expiration date, and current status. You may also view dependents who hold cards. If your card is lost or stolen, you may report it through this screen.



**Transactions** – Access a list of transactions across all accounts, sorted by date. Select a transaction to view details.



**Profile** – Access your profile and view information. You may edit information from this screen.



**Alerts** – View all alerts for your accounts and cards.

# How To Submit A Reimbursement Claim (FSA)

*All sections of the claim form must be completed in order to receive reimbursement.*

## Claim Form Section 1: Employee Information

The following information must be included for each claim:

- Employee (Participant) Social Security Number
- Employee Name
- Employee Address
- Employee Phone Number

## Claim Form Section 2: Claim Information

The following must be included for each claim:

### For Medical Expenses

- Date of Service
- Patient Name
- Name of Provider
- Description of Service
- Amount of Claim

### For Dependent Care Expenses:

- Date of Service
- Dependent Name
- Dependent Age
- Name of Care Provider
- Care Provider Address
- Provider Tax ID/SSN
- Amount of Claim

**For Medical Expenses**, you must provide a provider receipt or insurance carrier explanation of benefits (EOB) that contains ALL of the information listed under “For Medical Expenses” above. Cancelled checks, non-detailed credit card receipts, or generic cash receipts do not provide all the information necessary to substantiate claims and cannot be accepted. Statements with “Previous Balance”, “Balance Forward”, or “Paid on Account” do not contain all of the necessary information and cannot be accepted.

**For Dependent Day Care Expenses**, you must provide either a receipt that contains ALL of the information listed under “For Dependent Day Care Expenses” or a signature of the Care Provider on the completed claim form. Expenses submitted for Dependent Care reimbursement must allow the participant to be gainfully employed (or looking for work). Overnight camps, extracurricular activity fees, care for children over the age of 12, and private school fees (for grades Kindergarten and up) are not eligible expenses for Dependent Care reimbursement.

## Claim Form Section 3: Signature

The participant must sign and date the claim form in order for the claims to be reimbursed.

## For Reimbursement

- Upload with the Summit Mobile App using SnapClaim™; or,
- Enter the claim online and upload receipts via the Summit participant portal; or,
- Fax claim form and receipts to Little Rock **855-445-1696** or,
- Email claim form and receipts to **benefits@beneliance.com**; or,
- Mail claim form and receipt copies to:

**Beneliance**  
**PO Box 55068**  
**Little Rock, AR 72215**

**For a list of eligible expenses, see page 5 or visit [beneliance.com](https://beneliance.com)**

**For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP**

Beneliance | Toll-free: 877-685-0655 | Fax: 855-445-1696  
PO Box 55068, Little Rock, AR 72215 | [benefits@beneliance.com](mailto:benefits@beneliance.com) | [beneliance.com](https://beneliance.com)



# Claim Form – Health FSA Reimbursement or Card Substantiation

☐ Please check here if new mailing address

☐ Please check here if new email address

## Section 1: Employee Information

Employer Name (Please Print) \_\_\_\_\_

Employee Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Home Phone (    ) \_\_\_\_\_ Work Phone (    ) \_\_\_\_\_

Employee Email Address \_\_\_\_\_

## Section 2: Claim Information

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.  
All information below must be completed.

Debit Card Purchase?	Service Date (mm/dd/yyyy)	Patient Name & Relationship	Provider Name & Address	Description of Service	Amount
<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
<input type="checkbox"/> Yes <input type="checkbox"/> No					\$
Total					\$

## Section 3: Signature

### Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mm/dd/yy

For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP

Beneliance | Toll-free: 877-685-0655 | Fax: 855-445-1696  
PO Box 55068, Little Rock, AR 72215 | [benefits@beneliance.com](mailto:benefits@beneliance.com) | [beneliance.com](http://beneliance.com)

# Claim Form – DCAP Reimbursement

☐ Please check here if new mailing address      ☐ Please check here if new email address

Employer Name (Please Print) \_\_\_\_\_

Employee Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Home Phone (    ) \_\_\_\_\_ Work Phone (    ) \_\_\_\_\_

Employee Email Address \_\_\_\_\_

## Dependent Care Claims

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim. Use a copy of this form if you need more space. All information below must be completed.

Service Period		Dependent Name	Age	Provider Name & Address	Provider Tax ID#/SS#	Amount
From	To					
						\$
						\$
						\$
						\$
						\$
Total						\$

## Employee’s Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/ or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee’s Signature \_\_\_\_\_ Date    /    /  
mm/dd/yy

For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP

Beneliance | Toll-free: 877-685-0655 | Fax: 855-445-1696  
PO Box 55068, Little Rock, AR 72215 | [benefits@beneliance.com](mailto:benefits@beneliance.com) | [beneliance.com](http://beneliance.com)

# Election Form

- If not electing for the current year, please fill in name at top and sign at the very bottom to waive participation -

Employer Name (Please Print) \_\_\_\_\_ Payroll Effective Date \_\_\_\_\_

Employee Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Employee Email Address \_\_\_\_\_

I hereby authorize and direct my employer to reduce my earnings in the amount necessary to fund my Cafeteria Plan as indicated below. I understand such reductions, considered elective contributions under the Plan, will start with my first paycheck dated after the plan year begins. I understand that the purpose of this program is to allow employees to select qualified benefits within the guidelines of the Internal Revenue Code. I also understand that the flexible spending account plan(s) will allow me to be reimbursed for eligible out-of-pocket medical, dental, vision and/or dependent care expenses.

☐ I choose to participate in Flexible Spending Account (FSA) elections.

Health FSA – Medical Expenses .....\$ \_\_\_\_\_ (Annual Amt.)

DCAP – Dependent Care (Child Care) Expenses .....\$ \_\_\_\_\_ (Annual Amt.)

☐ I choose the debit card for my payment method.

I understand that the debit card is restricted to certain merchant categories and is not accepted at all Mastercard® acceptance locations. I understand that I may not obtain a cash advance with the debit card at any merchant, bank or ATM. I understand that the debit card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which I participate. If the debit card is issued pursuant to Employer Plans and I use the Card for an expense that is not a Qualified Expense I am indebted to my Employer and must repay the full amount of the non-qualified expense. I agree to save all invoices and receipts related to any expenses paid with the debit card; upon request I must submit these documents for review by my benefits administrator. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and I will be required to remit payment to my Employer. Payment may be in the form of an offsetting claim, personal check, electronic draft from my personal checking or savings account, a post-tax deduction from my paycheck, or other options established by my employer.

Additional Card Requested: Name on 2nd Card (cannot be same as Employee) \_\_\_\_\_

☐ I choose Direct Deposit for my payment method.

Routing Transit Number  
(All 9 boxes must be filled)

Account Number  
(Include hyphens, but not spaces or special symbols)

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

\_\_\_\_ ATTACH A VOIDED CHECK HERE \_\_\_\_

DO NOT attach a Deposit Slip because deposit slips often do not show all the needed information

I understand this salary reduction agreement will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in my family status. I hereby certify the above information to be correct and true and I choose to participate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

OR I choose not to participate in the FSA for this plan year (sign bottom line).

Signature \_\_\_\_\_ Date \_\_\_\_\_

Beneliance | Toll-free: 877-685-0655 | Fax: 855-445-1696  
PO Box 55068, Little Rock, AR 72215 | [benefits@beneliance.com](mailto:benefits@beneliance.com) | [beneliance.com](http://beneliance.com)



**Beneliance**

PO Box 55068 | Little Rock, AR 72215

Customer Service: Toll-Free 877-685-0655

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[beneliance.com](http://beneliance.com)